CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 333	**Date: April 18, 2008**
	Change Request 5979

SUBJECT: Assignment of Providers to MACs

I. SUMMARY OF CHANGES: In order to assist the Medicare community with the transition of workload from legacy FIs and carriers to the MACs, reassignment of a provider from one FI/MAC to another FI/MAC is generally frozen. This One Time Notification describes CMS' approach for assigning providers to MACs and discusses the process of moving providers to MACs.

NEW / REVISED MATERIAL
EFFECTIVE DATE: *May 19, 2008
IMPLEMENTATION DATE: May 19, 2008

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	Chapter / Section / Subsection / Title
N/A	

III. FUNDING:
SECTION A: For Fiscal Intermediaries and Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

SECTION B: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

One-Time Notification

**Unless otherwise specified, the effective date is the date of service.*

Attachment – One-Time Notification

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I Background

Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Public Law 108–173, amended Title XVIII of the Social Security Act (the Act) to add section 1874A, Contracts with Medicare Administrative Contractors (MACs). Section 1874A of the Act replaces the prior Medicare intermediary and carrier contracting authorities formerly found in sections 1816 and 1842 of the Act, respectively.

Moreover, in section 911(b) of the MMA, Congress repealed the provider nomination provisions formerly found in section 1816 of the Act. CMS procured the first A/B MAC in 2006 and continues to award the fifteen A/B MAC contracts. The process of moving workload from legacy contractors to the MACs has begun.

Joint Signature Memorandum (JSM) 05542, dated October 18, 2005, instructed all fiscal intermediaries (FIs) that, effective October 1, 2005, CMS would no longer accept an individual provider's request to move from one FI to another FI. However, a provider that was joining or leaving a Medicare chain (undergoing a change of ownership), was permitted to move from one FI to another FI in connection with that change of ownership.

Transmittal 291 (CR 5720), dated September 19, 2007, informed all FIs and A/B MACs that CMS would no longer accept a request to move from one FI/MAC to another FI/MAC from a provider moving in or out of a Medicare chain. There is one exception for a small subset of chains. They are "qualified chain providers" (QCPs), and are discussed below in IIE and Attachment B.

CMS implemented this freeze on movement of providers in order to support the process of transferring workload from legacy carriers and FIs to A/B MACs. CMS needs to stabilize chain configurations, provider assignments, and claim histories in anticipation of the MAC implementation. CMS also seeks to limit the number of transitions to which each provider is subjected.

II A Review of CMS' Approach for Assigning Providers, Physicians, and Suppliers to MACs

A Home Health & Hospice

All home health and hospice (HH&H) providers will be assigned to the MAC contracted by CMS to administer HH&H claims for the geographic locale in which the provider is physically located. See the following link for a description of the MAC-environment HH&H regions and the four MACs that will administer HH&H claims for those four regions.

http://www.cms.hhs.gov/MedicareContractingReform/06_SpecialtyMACJurisdictions.asp#TopOfPage

B Durable Medical Equipment

Each supplier of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) will submit claims to the DME MAC contracted by CMS to administer DMEPOS claims for the geographic locale in which the beneficiary permanently resides. The link above under IIA also provides a description of the MAC-environment DMEPOS regions and the four MACs that will administer DMEPOS claims for those four regions.

C Qualified Railroad Retirement Beneficiaries Entitled to Medicare

Physicians and other suppliers (except for DMEPOS suppliers) will continue to enroll with and bill the contractor designated by the Railroad Retirement Board (under Section 1842(g) of The Act) for Part B services furnished to these beneficiaries. Suppliers of DMEPOS will bill the DME MACs.

D Specialty Providers and Demonstrations

Specialty providers, and providers involved with certain demonstrations, will submit claims to a specific MAC designated by CMS. A list of those specialty services and their designated MACs is reflected in Attachment A.

E The Geographic-Assignment Rule

On November 24, 2006, CMS published a final regulation setting forth the "geographic assignment" rule for the balance of Medicare providers, physicians, and suppliers. The regulation (at 42 CFR 421.404) directs that Medicare providers, physicians, and suppliers will generally be assigned to the A/B MAC contracted by CMS to administer claims for the Medicare benefit category applicable to the entity's covered services for the geographic locale in which the entity is physically located. The A/B MACs will be contracted to serve all Medicare benefit categories not discussed above (under IIA – IIC) within their jurisdictions.

An exception exists for qualified chain providers (QCPs). A QCP may request that its member providers be serviced by a single A/B MAC - specifically, the A/B MAC whose jurisdiction includes the QCP's home office. See Attachment B for additional information.

A few providers that meet the "provider-based" criteria of 42 CFR 413.65 may present an additional exception to the geographic-assignment rule. Provider-based entities (other than home health and hospice (HH+H) providers) will be assigned to the MAC contracted by CMS to administer claims for the Medicare benefit category applicable to the provider's covered services for the geographic locale in which the main ("parent") provider is physically located.

III The Process of Moving Providers to MACs

A The General Case

All existing providers with a Medicare claims history will remain in their current FI/MAC assignments until their workload is transferred to an A/B MAC.

New providers (also known as "initial enrollments") will be assigned to the FI or MAC contracted by CMS to administer claims for the Medicare benefit category applicable to the provider's covered services for the geographic locale in which the provider is physically located. An exception exists for a "Multi-Provider Complex/Sub-Unit" relationship (ref: 42 CFR 483.5(b)). An initial enrollment for a sub-unit will be assigned to the FI or MAC that currently serves the existing parent hospital – even if the parent hospital is not presently billing in accordance with the "geographic assignment rule." Each such case is fact-specific and will be treated on an individual basis.

As each MAC contract is awarded, the new MAC will take over the workload performed by the carriers and FIs that serviced the state(s) in the given MAC jurisdiction. The Part A and Part B workload segments for each of the states in the given MAC jurisdiction will be moved one-by-one in the 12 months following the award. The specific requirements associated with workload transfers will be directed through formal CMS transmittals.

B Out of Jurisdiction Providers

An "out-of-jurisdiction provider" (OJP) is a provider that is not currently assigned to the A/B MAC or FI in accordance with Sections IIA – IIE above (including the geographic assignment rule.) For example, an individual, freestanding provider located in Oregon, but currently assigned to the Florida FI, would be an OJP.

Many legacy Part A workload segments may include a number of OJPs. Examples of how an OJP may have been assigned to the given Part A segment include:

1. Individual "provider nominations." (Note MMA §911 repealed the provider nomination provisions of the Act.); or

2. Chains being granted "single FI" status.

New MACs will initially service some OJPs until CMS undertakes the final reassignment of all OJPs to their destination MACs based on the geographic assignment rule.

CMS will start the overall transfer of OJPs to their final destination MACs after all 15 A/B MACs have been implemented. Some providers will need to submit or update their Medicare enrollment record before being reassigned.

When CMS starts the overall transfer of OJPs, the timing of each individual OJP move will be dependent on the then-current implementation status of the health Insurance General Ledger Accounting System (HIGLAS), the status of the Enterprise Data Centers, and any other factors affecting the ability of the destination MAC to accept the OJP and its Medicare claims history.

IV Updating Medicare's Internet-Only Manuals

CMS is aware that Medicare program stakeholders may have additional questions about the assignment of providers, physicians, and suppliers to the A/B MACs. At the time that each A/B MAC is implemented, CMS intends to communicate explicit guidance on these issues to each set of incoming and outgoing contractors through the issuance of formal "change requests." CMS also intends to review whether additional changes to the permanent Internet-Only Manuals are required to clarify the full range of issues surrounding jurisdiction for claims in the MAC environment. CMS may establish a contractor workgroup to analyze potential changes to the Internet-Only Manuals. Any contractor having views on these issues and/or potential interest in participating on a claims jurisdiction workgroup should communicate to Mark Zobel at mark.zobel@cms.hhs.gov or Brian Johnson at brian.johnson@cms.hhs.gov.

V Provider Education Table

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
5979.1	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X		X	X	X					

VI Supporting Information

See attachments.

VII Contacts

Pre-Implementation Contact(s):

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Post-Implementation Contact(s):

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VIII Funding

Section A: For *Fiscal Intermediaries (FIs), Carriers, and Regional Home Health Carriers (RHHIs)*:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *For Medicare Administrative Contractors (MACs)*:

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Attachments

Attachment A

MACs Designated to Process Specialty or Demonstration Claims

Specialty Service or Demonstration	MAC Jurisdiction
Centralized Billing for Mass Immunizers	4
Indian Health Services	4
Low Vision Demonstration	5,10, 11, 13, and 14
Rural Community Hospital Demonstration	1, 2, 4 and 5
Veterans Affairs Medicare Equivalent Remittance Advice Project	4
Chiropractic Services Demonstration	4 and 5
Home Health Third Party Liability Demonstration Project	14
Medicare Adult Day Care Demonstration	11, 14 and 15
Independent Organ Procurement Organizations	10
Religious Non-medical Health Care Institution (RNHCI)	10
Histocompatibility Lab	10

Attachment B

The regulation at 42 CFR 421.404(b)(2) defines a qualified chain provider (QCP) as:

- Ten or more hospitals, skilled nursing facilities, and/or critical access hospitals, under common ownership or control, collectively totaling 500 or more certified Medicare beds; or

- Five or more hospitals, skilled nursing facilities, and/or critical access hospitals, under common ownership or control in three or more contiguous states, collectively totaling 300 or more certified Medicare beds.

A QCP may have all its eligible providers assigned to the A/B MAC that covers the state where the QCP's home office is located.

If the QCP acquires a new hospital, skilled nursing facility, or critical access hospital that is located outside of the home office A/B MAC jurisdiction, then CMS will endeavor to assign the initial enrollment to the FI or MAC that covers the QCP's home office state.

CMS may assign non-QCP providers, as well as ESRD suppliers to an A/B MAC outside of the prevailing geographic assignment rule only to support the implementation of the MACs or to serve some other compelling interest of the Medicare program. (42 CFR 421.404(b)(4) and (c)(3).)